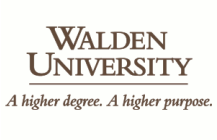

2015

The Predictors of Physician-Patient Discussions of Sexual Health with Older Adults

Dana Marie Werner
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Dana Werner

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Review Committee
Dr. Sandra Rasmussen, Committee Chairperson, Psychology Faculty
Dr. Anthony Napoli, Committee Member, Psychology Faculty
Dr. Rachel Piferi, University Reviewer, Psychology Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2015

Abstract

The Predictors of Physician-Patient Discussions of Sexual Health with Older Adults

by

Dana Marie Werner

MA, University of Phoenix

BA, Gwynedd-Mercy College

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

Walden University

February 2015

Abstract

The number of adults aged 65 years and over has been rising quickly, as has the rate of new onset sexually transmitted diseases within this population. Discussions of sexual health between physicians and older adults are currently lacking in frequency and effectiveness. Using the foundation of stereotype embodiment theory, the purpose of this study was to identify the factors that predict frequency of discussing sexual health with older adult patients. A comparative sample of geriatric physicians and family practitioners completed 2 researcher-developed questions and the Sexual Health Care Scale-Attitude tool that assessed their stereotype beliefs toward discussing sexual health with older adults using the 4 subscales-- personal, patient, environmental, and colleague-- and the frequency with which they discussed sexual health with their older adult patients. It was hypothesized that non-ageist attitudes would increase the frequency of discussions, and increase the personal factors, such as comfort level, of having such discussions. Multiple regression analysis and the chi-square test were used in data analysis. Frequency of sexual health discussions with older adult patients was dependent upon the physician type, age and gender, and how well the physician believed he or she had been educated to discuss sexual health with older adults. Comparatively, the geriatric physicians had more frequent discussions of sexual health with older adults than the family practitioners. The implications for social change include identifying the need for more specialized physician training in discussing sexual health with older adults to improve overall physical and emotional well-being of older adults and the study's recommendations for future research.

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Dedication

This paper is dedicated to my loving husband, Michael, for always encouraging me to do more, to give more, and to be more. Thank you for all the crazy nights of listening to my endless statistical chatter and for wiping my tears when I felt weak and afraid. I know it is my name on this, but really it should be yours because without your love and support I could not have done any of this. You are the other half of my soul, my butterfly, and always my Monkey. “Loving you bunches and bunches…forever and ever…always, AMEN.”

I would also like to dedicate this to my Nana and Pop-pop. I hope you both can read this in Heaven. I miss you and I love you always.

Finally, I have to dedicate part of this to our Bob. To others you may be “just a cat” but for me you are the best classmate anyone could have. No more “going to school” Bob, mommy is done!

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Thank you, Dr. Alm, for getting me started on this journey. I hope Heaven allows you to see me cross the finish line.

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Thank you to my parents, (Dad & Sandy, Mom & Bob), for all your love and support along this journey.

Thank you to everyone at American Legion Post 308 in Willow Grove PA. You all mean the world to me. “Us and Those Like Us”.

Thank you to all my friends, my sisters from other misters, and my brothers from other mothers. Love you all.

And thank you to all my “kids” who seem to be growing up too fast. Aunt Dana loves you to the moon and back!

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Chapter 1: Introduction to the Study

As of 2011, there were 40.3 million older adults age 65 and over, 13% of the total United States population (U.S. Census, 2011). By the year 2030 population estimates reported that 1 out of 8 Americans will be age 65 or over, with those over 85 years of age becoming the fastest growing age group (Narang et al., 2010). As the aging population rises, so do the risk and rates of sexually transmitted diseases (STDs), especially among those 65+ years who have been found to be less knowledgeable regarding STDs, their own risk for STDs and sexually transmitted infections (STIs), and the transmission of STDs and STIs (Lynch, 2012; Paul, Martin, Shou-En, & Young, 2007). This lack of knowledge has resulted in lower rates of condom usage among older adults (Hatchett & Duran, 2002; Williams & Donnelly, 2002). Research has indicated that older adults do not use condoms because the risk of pregnancy is not a concern among post-menopausal females (Hatchett & Duran, 2002; Williams & Donnelly, 2002). Condom usage has been associated with decreased sensation and discomfort among older men, especially those with erectile dysfunction (Hatchett & Duran, 2002). For both older males and older females, condom usage at older ages has been associated with prostitution and uncleanliness of partner (Hatchett & Duran, 2002). STDs and STIs among the older adult population are often misdiagnosed or unrecognized by physicians who do not discuss sexual health with their older adult patients, which may lead to major public health implications (Bilenchi et al., 2009; Lindau et al., 2007; Lynch, 2012; Paul et al., 2007; Snyder & Zweig, 2010).

Sexual health is an important aspect of the older adult's life (Kane, 2008; Thompson et al., 2011), and undiscussed problems or concerns have been linked to negative mental health, such as depression or social withdrawal, and can also be a consequence or warning sign of an underlying medical condition, such as diabetes, infection, urogenital tract conditions, or cancer (Lindau et al., 2007; Thompson et al., 2011). In some instances, experiencing negative sexual side effects from medications and treatments will lead the older adult to become noncompliant to his or her medical care regime (Lindau et al., 2007). Although there is an unwillingness by both the patient and the physician to initiate sexual heath discussions (Lindau et al., 2007), older adults have been reported to want their physicians to initiate sexual health discussions with them during routine office visits (Kane, 2008; Lindau et al., 2007; Paul et al, 2007).

This chapter includes background, purpose of this study, statement of the problem, the research questions and hypotheses, and the theoretical framework for this study. Definition of terms, significance of the study, and the assumptions and limitations of the study are also discussed in this chapter.

Background

Researchers have reported the lack of sexual health discussions between physicians and older adult patients in the literature as being related to the physicians' lack of aging process knowledge and physician personal bias (Bilenchi et al, 2009; Bouman & Arcelus, 2001; Lindau et al., 2007; Smith et al., 2007). Although there are clear definitions for sexual activity and sexual health, authors of past studies did not indicate whether one type of discussion occurred in the absence or presence of the other. For the

purpose of this study, I primarily used the term *sexual health*. Researchers reported lack of education specific to older adult sexuality and sexual health needs to be limited in the training of physicians (Comanche & Reyes-Ortiz, 2005). Personal bias may be rooted in ageism (Cottle & Glover, 2007) as explained by stereotype embodiment theory. Stereotype embodiment theory explains ageism as a subconscious internalized set of beliefs about old age and older adults that is formed, and reinforced, by lifetime exposure to cultural and societal messages of ageism (Levy, 2009). A result of such ageism is the perception and treatment of older adults as being genderless, disinterested in sexual activity, and incapable of sexual activity (Kane, 2008; Paul et al., 2007) despite older adults remaining sexual active throughout their life spans (Kane, 2008; Lindau et al., 2007; Thompson et al., 2011).

Previous researchers have concluded that exposure and familiarity with older adults, and increased education regarding the aging process, can have an impact on reducing ageist beliefs and bias (Hagestad & Uhlenberg, 2005; Pettigrew, 1998). This thereby increased the physician's ability to recognize potential sexual health problems and increased physician initiated sexual health discussions with their older adult patients (Kane, 2008; Lindau et al., 2007). Existing studies regarding sexual health discussions between physicians and their older adult patients did not include geriatric physicians. Geriatric physicians, due to their increased aging process knowledge and increased exposure and familiarity with older adults, as compared to general physicians, may provide keen insight to interventional steps that various health care providers need to be

implemented to meet the sexual health needs of the aging population by identifying the predictive factors that block and facilitate sexual health discussions with older adults.

Purpose of the Study

The purpose of this study was to explore whether geriatric physicians had more frequent discussions about sexual activity and sexual health with their older adult patients than general physicians. The predictive factors that blocked or facilitated these discussions were also investigated by quantitatively examining results from the geriatric physicians and comparing them with those from general physicians with older adult patients. This comparison identified the role of education in reducing ageism and increasing frequency of sexual health discussions.

Statement of the Problem

Researchers have reported that STDs among adults aged 65+ years and older are on the rise and are often misdiagnosed or unrecognized by physicians who do not discuss sexual health with their older adult patients, which may lead to major public health implications (Bilenchi et al., 2009; Lynch, 2012; Snyder & Zweig, 2010). The lack of sexual health discussions between physician and older adult patients have been reported in the literature as being related to the physicians' lack of aging process knowledge and physician personal bias (Bilenchi et al., 2009; Bouman & Arcelus, 2001; Lindau et al., 2007; Smith et al., 2007).

These previous studies only included general physicians, not geriatric physicians. The purpose of this study was to explore whether increased aging education of the geriatric physician was related to lower rates of ageist ideals, increase frequency of

discussions about sexual health with older adult patients, and a higher comfort level in such discussions than with the general physicians.

Research Questions and Hypotheses

The following research questions and hypotheses were derived from the review of existing literature regarding physician discussions of sexual activity and sexual health with their older adult patients.

Research Question 1: Do geriatric physicians and general physicians equally discuss sexual health with their older adult patients?

Null Hypothesis 1: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's discussing sexual health with their older adult patients does not differ significantly from zero.

Alternative Hypothesis 1: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's discussing sexual health with their older adult patients does differ significantly from zero.

Research Question 2: Does age of the physicians predict the frequency of discussing sexual health with older adults?

Null Hypothesis 2: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's age does not differ significantly from zero.

Alternative Hypothesis 2: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's age does differ significantly from zero.

Research Question 3: Does gender of the physicians predict the frequency of discussing sexual health with older adults?

Null Hypothesis 3: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's gender does not differ significantly from zero.

Alternative Hypothesis 3: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's gender does differ significantly from zero.

Research Question 4: Do physicians report similar educational training that predicts the frequency of discussing sexual health with older adults?

Null Hypothesis 4: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's educational training does not differ significantly from zero.

Alternative Hypothesis 4: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's educational training does differ significantly from zero.

Research Question 5: Do physicians report personal factors that predict the frequency of discussing sexual health with their older adult?

Null Hypothesis 5: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting personal factors does not differ significantly from zero.

Alternative Hypothesis 5: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting personal factors does differ significantly from zero.

Research Question 6: Do physicians report patient factors that predict the frequency of discussing sexual health with older adults?

Null Hypothesis 6: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting patient factors does not differ significantly from zero.

Alternative Hypothesis 6: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting patient factors does differ significantly from zero.

Research Question 7: Do physicians report environmental factors that predict the frequency of discussing sexual health with older adults?

Null Hypothesis 7: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting environmental factors does not differ significantly from zero.

Alternative Hypothesis 7: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting environmental factors does differ significantly from zero.

Research Question 8: Do physicians report colleague factors that predict the frequency of discussing sexual health with older adults?

Null Hypothesis 8: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting colleague factors does not differ significantly from zero.

Alternative Hypothesis 8: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting colleague factors does differ significantly from zero.

Theoretical Framework

The theoretical framework for this study was rooted in stereotype embodiment theory (Levy, 2009). Key to this theory is that ageist thoughts, beliefs, and behaviors are subconsciously acted upon as a result of lifetime exposure to ageist ideals. The life-time exposure to the idea that older adult sexuality is nonexistent can often be found within children stories and media portrayals (e.g., older adults sleeping in separate beds or rooms). Scholars have noted that the representation of older adults in media portrayals shape and reflect the cultural norm perception of older adults by displaying myths associated with aging and reinforcing the negative stereotypes associated with aging (Mason, Darnell, & Prifti, 2010). This subtle exposure helps to form the attitudes toward older adults as being asexual and not interested in sexual intimacies in later life. On the more extreme side, sexuality in older age is often portrayed humorously, such as in the movie *Grumpy Old Men*, or as socially taboo as in the movie *Harold and Maude* and *The Graduate.*

The negative media portrayals of older adults and the aging process have been noted to influence the development of aging stereotypes and ageist beliefs among

children and young adults, especially when personal contact with older adults is limited or perceived by parents as a negative interaction (Mason et al., 2010). How children perceive their parents reacting toward older adults may also influence the children's perception of older adults. Subsequently, through learned association, a child begins to instinctively react toward, and hold beliefs toward, older adults that mimic those of the parents (Duncan & Schaller, 2007). These early perceptions can influence subconscious thoughts, beliefs, and behaviors toward older adults across the life span. Parental responses of guiding children away from an older adult that does not appear *healthy* due to normal aging changes such as skin wrinkling and discoloration, and children hearing their parents negatively discuss the burden of an older loved one or complain about an older adult who may be driving too slow or holding up a grocery line, can elicit ageist thoughts, beliefs, and behaviors at the mere sight of an older adult (Duncan & Schaller, 2009).

This theory relates to the study approach and research questions in that measurement scores for the factors were correlated to frequency of sexual health discussions. Stereotype embodiment theory is discussed further in Chapter 2.

Nature of the Study

This was a non-experimental quantitative study that used two researcher-developed questions and the Sexual Health Care Scale-Attitude (SHCS-A) standardized tool (Kim, Hee, & Kim, 2011) to assess the factors that predict the frequency of discussing sexual health with older adult patients using a comparative sample of geriatric physicians and general physicians.

The predictor variables were the type of physician (geriatric physicians or general physicians), age of the physicians, gender of the physicians, education of the physicians, personal factors, patient factors, colleague factors, and environmental factors.

Chapter 3 includes further detail regarding research design and rationale, targeted survey participant eligibility, and sampling procedures. Issues pertaining to instrumentation, reliability, and validity are also discussed in Chapter 3, as are data analysis procedures and ethical considerations.

Definition of Terms

Ageism: An aversion and prejudice toward the aged that leads to discrimination and discriminatory behavior based on age (Butler, Lewis, & Sunderland, 1991).

Ageist: A set of thoughts, beliefs and behaviors associated with stereotypes of aging and the aged as found within ageism.

Family practitioner and *general physician:* A medical doctor who practices in family medicine and did not receive specialized education in geriatric medicine.

Geriatrician and *geriatric physician:* A medical doctor who has received specialized medical training dealing with the problems specific to older age and the aging process (Hampton, Craven, & Heitkemper, 1997).

Older adult: For the purposes of this research, *older adult* referred to any person aged 65 years and over.

Sexual activity: Sexual activity includes, but is not limited to sexual expressions that include kissing, hugging, intimate touching, vaginal and anal intercourse, solo and

partnered masturbation, and oral-genital stimulation (Bentrott & Margrett, 2011; Palacios-Cena et al., 2012).

Sexual health: Using the working definition from the World Health Organization (2002), sexual health is a state of physical, mental and social well-being in the relation to sexuality in the absence or presence of disease, infirmity or dysfunction, and as having the potential for safe and pleasurable sexual experiences that are void of discrimination, coercion, and violence.

Sexually transmitted infection (STI) and *sexually transmitted disease (STD):* Although *STI* is becoming the more conventionally accepted term to refer to sexually transmitted infections, this paper primarily used *STD* since it is more appropriate to older adults who are often diagnosed later than their younger counterparts and when the infection has reached the disease phase (Williams & Donnelly, 2002).

Assumptions

It was assumed that the geriatric physician and general physician had older adult patients in their practices and that the physicians responded honestly on the survey. It was also assumed that the increased aging process education possessed by the geriatric physician resulted in this group reporting that they had fewer personal factors that would block discussing sexual health with older adults. Dishonest responses on the survey may have been from social desirability bias or the tendency of individuals to respond in such a way that they think to be appealing to the greater community or to the researcher. Not having older adults, or very few older adults, in their practice may have also influenced

dishonest responses as the physician may have wanted to participate actively in the study, yet did not have the population experience from which to draw their responses.

Scope and Delimitations

A random sampling of physicians in the United States who self-identify as specializing in *geriatric medicine* and *family medicine* was used to determine physician eligibility. The organization Healthcare Data Solutions was used to identify eligible physicians and to e-mail the physicians the link to the questionnaire that was available on surveymonkey.com. Physicians for each category were considered eligible for survey participation. Physicians who shared an office with a previously selected physician from either category were considered ineligible for the study and the next eligible physician was selected. Physicians who identified themselves as *pediatricians* or specializing in *pediatric medicine* were considered ineligible for the study as it was assumed that they did not treat older adults within their practices. Physicians who self-identified as specializing in *hospice care* or *palliative* care, for either category, were also considered ineligible for study participation as end-of-life medical care vastly differs from the scope and treatment that this study explored.

Limitations

A limitation of this study was the amount of older adult patients seen by the general physician (e.g., a large amount or none at all) as exposure, or lack thereof, to older adults may influence ageist thoughts, beliefs, and behaviors (Hagestadt & Uhlenberg, 2005; Pettigrew, 1998). The assumption that general physicians receive little educational training in older adult sexuality was also a limitation of this study. Findings

from this study were limited to geriatric and family medicine and are not be generalizable to other medical specialties.

Significance

This research project was important because it addressed the under-researched area of sexual health discussions occurring between geriatric physicians and their older adult patients. Previous researchers reported that 20% to 30% of older adults (n = 1,974) remained sexually active well into their 80s with very low condom use reported (Schick et al., 2010), and 54% of older adults age 75 to 85 years (n = 893) reported having sex at least two to three times per month, with 23% having sex at least once a week or more (Lindau et al, 2007). The results of this research, as gained from the geriatric physicians, provided insights to interventional steps, such as additional and on-going training specific to older adult sexual activity and sexual health, needing to be implemented to meet sexual health needs of the aging population from various health care providers.

The implications for social change from this research can raise awareness of the need for more specialized training in how to effectively discuss sexual activity and sexual health with older adults to provide a true holistic approach to health care.

Summary

This non-experimental research study identified the predictive factors that block or facilitate discussing sexual health with older adult patients using a comparative sample of geriatric physicians and general physicians within the United States. The use of the Sexual Health Care Scale- Attitude standardized tool and two researcher-developed questions identified the predictive factors that block or facilitate discussions by assessing

the stereotype beliefs toward older adults and older adult sexuality. This study was based on stereotype embodiment theory, which purports that ageist thoughts, beliefs, and behaviors are subconsciously acted upon as a result of lifetime exposure to ageist ideals. Chapter 2 presents the literature pertinent to this study. Chapter 3 presents the study's methodology. Chapter 4 presents the results of the analysis, and Chapter 5 presents the implications of the results and conclusions.

Chapter 2: Literature Review

Introduction

The amount and frequency of sexual activity in later life may decline over the life-span, yet for most older adults sexual activity and sexual health remains an important aspect of their overall well-being and a positive quality indicator of their life satisfaction (Benstrott & Margrett, 2011; Hillman, 2011; Kane, 2008; McAuliffe, Bauer, & Nay, 2007; Nusbaum, Singh, & Pyles, 2004; Thompson et al., 2011). The growing aging population and increasing life expectancy has made discussions of sexual activity and sexual health by physicians with older adult patients a much needed and timely research topic (Bouman, Arcelus, & Benbow, 2006). This population increase will mean that older adults will remain sexually active much longer throughout their life-spans and, as such, will expect their physicians to be knowledgeable about sexual health in late life (Kennedy, Martinez, & Garo, 2010).

Physicians have been identified as the appropriate source to address sexual activity and sexual health concerns with older adults (Gott et al., 2004). Past studies have indicated that physicians neglected to discuss sexual health with their older adult patients because of a lack of aging process knowledge and understanding, especially in the area of sexual activity in later life (Gott et al., 2004; Hillman, 2011; Smith et al., 2007: Snyder & Zweig, 2010). Limited knowledge is available among general physicians regarding older adult sexual activity and sexual health needs (Camacho & Reyes-Ortiz, 2005), which may be indicative as to why these general physicians do not frequently discuss sexual health

with their older adult patients and perceive sexual health and sexual risk taking as a topic for the young and not the old (Bouman et al., 2006).

When physicians do discuss sexual health with their older adult patients, the conversation gives the older adult the opportunity to discuss concerns and to report any STD symptoms that the older adult may not have otherwise reported (Camacho & Reyes-Ortiz, 2005) or which could have been misattributed to aging process diseases. Asking about sexual activity and discussing sexual health with the older adult patient may also allow for insight into other health conditions. Sexual performance problems in older adults can be a warning sign of other conditions or underlying illnesses (Bitzer, Platano, Tschudin, & Alder, 2008). Sexual problems in older age have been linked to negative mental health well-being (e.g., depression and social withdrawal) and a consequence or warning sign of underlying medical illness, such as diabetes, infection, urogenital tract conditions, or cancer (Lindau et al., 2007; Thompson et al., 2011). Discussing sexual health can also help to monitor whether older adults are compliant with their medication regime. Medication, especially those with sexual side effects, may go untaken by the older adult when he or she perceives the sexual side effect as more troublesome than the presenting problem (Hillman, 2008; Lindau et al., 2007).

Authors of studies of older adults and sexual risks concluded that older adults lacked in knowledge regarding STD prevention and transmission, as well as their own sexual risk behaviors (Bowman et al., 2006; Paul et al., 2007). The lack of sexual health discussions between physician and older adult patients may actually put the older adult at greater risk for infection (Williams & Donnelly, 2002) when patient concerns are not

openly discussed. STDs are often misdiagnosed or unrecognized in older adult patients when physicians do not discuss sexual health with their older adult patients (Bilenchi et al., 2009; Lynch, 2012). Disease symptoms common to the elderly or the aging process, such as weight loss, decreased physical and mental abilities, fatigue, Alzheimer's, Parkinson's, and respiratory disorders, can be indicative of early HIV or other STD symptoms (Williams & Donnelly, 2002). Many STD symptoms mimic other diseases thereby going unrecognized or misdiagnosed (Hillman, 2008). Physicians are more likely to discuss HIV and STD risk with their patients under 30 years of age than with their patients over 50 years of age (Williams & Donnelly, 2002).

Literature Search Strategy

A search of the literature was conducted digitally through electronic psychology and health databases such as PsycINFO, PsycARTICLES, and MEDLINE through Walden University and through Google Scholar linked to the Walden University Library. The list of search terms used to conduct the literature search consisted of *older adults, old age, geriatrics, geriatricians, physicians, family practitioners, sexual activity*, and *sexual health*. All articles obtained and reviewed for this study were obtained digitally.

Independent Variable

The independent variable for this study was frequency of sexual health discussions with older adults.

Predictor Variables

The predictor variables for this study were type of physician, age of physicians, gender of the physicians, education of the physicians, and the items of the four subscales: personal, patient, environmental, and colleague.

Theoretical Foundation

The theoretical framework for this dissertation was rooted in stereotype embodiment theory (Levy, 2009). Key to this theory is that ageist thoughts, beliefs, and behaviors are subconsciously acted upon as a result of lifetime exposure to ageist ideals. One study identified ageist thoughts, beliefs, and behaviors in children as young as 4 years of age and also identified these same thoughts, beliefs, and behaviors among those that work with the older adult population (Cottle & Glover, 2007). This indicated that ageist thoughts, beliefs, and behaviors form in the early years and will remain as such throughout the life-course. A personal bias or ageism, once formed, may influence interactions and perceptions of older adults. Life-time exposure to societal and cultural norms that view sexuality negatively in later-life and something not to be discussed with one's elders can influence the physician's willingness and ability to have such discussions with his or her older adult patients (Brennan, Emlet, & Eady, 2011). Personal attitudes or bias regarding late-life sexual activity contributes to physicians not discussing sexual activity and sexual health with their older adult patients (Allen, Petro, & Phillips, 2009).

Research has indicated that improving, or the addition of, aging process education within physician curriculum, specifically in the area of older adult sexual activity and

sexual health, could not only improve knowledge (Cottle & Glover, 2007), but also reduce the ageist ideals that deter sexual health discussions between physician and older adult patient (Cottle & Glover, 2007; Kane, 2008; Lindau et al., 2007).

The rationale for using stereotype embodiment theory as the foundation for this study was that ageist thoughts, beliefs, and behaviors become internalized and are acted upon at the subconscious level (Levy, 2009). This results in conflicting personal and professional ability to discuss sexual health with older adult patients. Physicians may be professionally aware of the importance of late-life sexual activity and sexual health (Maes & Louis, 2003), yet the personal internalized and subconscious belief that older adults are not sexually active nor are they concerned with sexual health issues (Brennan, Emlet, & Eady, 2011; Gott et al., 2004; Hillman, 2011; Maes & Louis, 2003; Smith et al., 2007) may produce an overall discomfort with such discussions despite the absence or presence of educational knowledge.

Conceptual Framework

Older adult sexuality has been traditionally viewed negatively by society (Hillman, 2008). Societal ageism consists of several assumptions and stereotypes about the aging process, especially in regards to late-life sexual activity and sexual health. These negative assumptions and stereotypes include the belief that older adults are asexual and without sexual desire (Bauer et al., 2007; Bouman et al., 2006), they are not and should not be sexually active (Bancroft, 2007; Bitzer et al., 2008; Williams & Donnelly, 2002), sexual activity is for the young, women stop having sexual relations after menopause, and late-life sexual activity is disgusting (Bouman et al., 2006). These

same societal assumptions and stereotypes have also been found to exist within physicians who work with older adult patients (Bauer et al., 2007; Bouman et al., 2006).

Negative societal ageism about late-life sexuality has often been cited as a reason for the lack of sexual health discussions between physicians and older adult patients (Allen et al., 2009; Bauer et al., 2007; Bouman & Arcelus, 2001; Gott et al., 2004; Lindau et al., 2007; McAuliffe et al., 2007). This negative societal ageism helps to create, as explained by the stereotype embodiment theory (Levy, 2009), physician perception and treatment of older adults as being genderless and disinterested in sexual activity (Kane, 2008; Paul et al., 2007). Lack of or limited educational learning reinforces learned societal ageism (McAuliffe et al., 2007). Increased aging process knowledge, as found within education, has been noted to be influential in decreasing ageist ideals and increasing the frequency of sexual health discussions between physicians and older adult patients (McAuliffe et al., 2007).

Sexual Activity among Older Adults

Older adults do not lose their desire for sexual closeness or expression (Bentrott & Margrett, 2011). Several studies have concluded that older adults remain sexually active throughout their later years. Results of a pilot study of older adults aged 75 years and older indicated that 42% of the males and 18% of the females were sexually active within the past year (Smith, Mulhall, Deveci, Monaghan, & Reid, 2007). In a similar study it was reported that 53% of males and 21% of females, aged 70 to 80 years, had been sexually active in the past year (Moreira et al., 2005). In a larger study, 20% to 30% of both males and females remained sexually active well into their 80s with some

reporting having sex at least two to four times a week (Schick et al., 2010). These findings were supported by another study that found 54% of men and women aged 75 to 85 years had sex at least two to three times per month, 23% had sex at least once a week or more, and 31% engaged in oral sex activities (Lindau et al., 2007). In a study focused specifically on the sexual activity of older adult females (n = 1,235) it was reported that 51.7% of those aged 60 to 69 years, 32.6% of those aged 70 to 79 years, and 13.5% of those aged 80 to 89 years were sexually active within the previous six months (Thompson et al., 2011).

Lack of and inconsistent condom use is often found within studies of sexual activity within older adulthood. One study of HIV positive middle to old age adults, 45 to 71 years, focusing on condom use within the past six months, reported that 20% of the males and females did not use condoms consistently, 33% had multiple partners in the previous six months, and 15% were in a monogamous relationship (Illa et al., 2008). Specifically, 46% of the males in this study reported one or more sexual partner in the past six months and 5% reported having 10 or more sexual partners in the previous six months (Illa et al., 2008). Of the females in this study, 14% reported one or more sexual partner in the previous six months and 2% reported having 14 or more sexual partners in the previous six months (Illa et al., 2008).

STDs, HIV/AIDS and Older Adults

Discussing sexual health should be part of older adult routine physician visits (Gleason-Comstock et al., 2008; McAuliffe et al., 2007; Schick et al., 2010). These assessments are not only appropriate to evaluate for any sexual problems, but to also to

educate on STI and STD prevention and condom use, as well as to discuss any concerns the older adult patient may not have otherwise mentioned if an assessment was never performed (Schick et al., 2010). Untreated STIs in older adults has been associated with increasing risk of contracting other STIs, including HIV/AIDS, and other STDs (Smith & Christakis, 2009).

Previous studies indicated that sexually active older adults, with two or more partners per year, report inconsistent condom use or no condom use during sexual activities (Lovejoy et al., 2008; Smith & Christakis, 2009). This inconsistent or lack of condom use is often associated with conception no longer being a concern for the older adult, lack of factual knowledge concerning STI and STD transmission, poor sexual health knowledge, and low self-perception of sexual risk taking (Maes & Louis, 2003; Morton, Kim, & Treise, n.d).

Older adults have been reported to have limited knowledge of STDs and HIV/AIDS risk specific for their age group. Previous studies have concluded that older adults are less knowledgeable about STDs and HIV/AIDS in terms of transmission and progression, as well as their own risk factors (e.g., age-related changes and risky sexual behaviors) that contribute to their risk of contracting an STD or HIV/AIDS (Bowman et al., 2006; Lynch, 2012; Maes & Louis, 2003; Paul et al., 2007). Increased age has been associated with false knowledge of STI transmission (e.g., exposure to myths versus factual information) and decreased perception of susceptibility to STDs and HIV/AIDS (Illa et al., 2008; Morton et al., n.d). Physiological changes associated with the aging process, such as the thinning and easily tearing vaginal and anal walls during penetrative

sexual contact, and age-related immune system changes places older adults at a greater risk for acquiring an STI, as well as transitioning faster to an STD and from HIV to AIDS (Illa et al, 2008).

Research has concluded that the lack of STD and HIV/AIDS knowledge found among older adults is compounded by an equal lack of process knowledge among physicians (Shippy & Karpiak, 2005). Current Center for Disease Control (CDC) guidelines do not indicate routine STD or HIV testing for those over the age 65 (Hillman, 2011) nor does the CDC report on new cases of STDs or HIV/AIDS for those aged 65 years and over (Shippy & Karpiak, 2005). This lack of guidelines and reporting may influence the belief, of the older adults and the physicians that older adults are not at risk for STDs and HIV/AIDS.

The rate of late-life onset of STDs and HIV/AIDS is expected to rise as the aging population continues to increase (Gott et al., 2004; Morton et al., n.d). This expected rise brings with it an expectation of increased discussions of sexual health between physicians and older adult patients (Gott et al., 2004). Since STIs, STDs and HIV/AIDS in older adults mimic symptoms of age-related health problems, discussing sexual health is an important component to decrease delays in diagnosis and treatment (Shippy & Karpiak, 2005).

Physician Sexual Health Discussions with Older Adult Patients

Despite evidence to the contrary, the general assumption, or bias, remains that older adults do not engage in sexual activity (Orel, Spence, & Steele, 2005). Societal bias dictates that sexual activity is reserved for the young, physically attractive, and for those

in their reproductive years (Bentrott & Margrett, 2011). This general assumption often carriers over into healthcare and can influence the physician not to discuss sexual health with their older adult patients (Maes & Louis, 2003; Orel et al., 2005). For example, in a qualitative study of general physicians, results indicated that physicians acknowledged the importance of discussing sexual health with older adult patients. However, they rarely had these discussions with their older adult patients (Gott, Hinchliff, & Galena, 2004) despite reports of older adults wanting these discussions to occur with their physicians to acquire appropriate care, treatment, and knowledge regarding their concerns (Lindau et al., 2007; Paul et al., 2007; McAuliffe et al., 2007). Some physicians have also reported that the routine office visit was not the appropriate place nor time to discuss sexual health since the presenting problem is of the main concern (Nusbaum & Hamilton, 2002; Pakpreo, 2005).

Some research indicated a gender difference in initiating discussions of sexual health with their physicians. Results of one study found that 22% of older aged men initiated discussions of sexual health with their general physician, 32% had the physicians initiate the discussion with them, and 86% believed the physician should routinely discuss sexual health during regular office visits (Smith et al., 2007). In the same study, 4% of the female participants initiated the discussion, 7% had the physician initiate the discussion, and 32% believed the physician should routinely discuss sexual health during regular office visits.

The predominate desire of older adult women to have their physicians initiate discussions about sexual health was supported by another study. In this study, 68% of

women aged 65 years and older reported having no discussions of sexual health with their physician, 10% reported having a physician initiated discussion, 22% of the participants initiated discussions with their physicians, and 97% of the participants reported that they would have discussed their sexual health if the physician had initiated the discussion or had asked them about their sexual activity (Nusbaum et al., 2004). Of the 32% that had discussions, patient and physician initiated, 59% felt that their concerns were not discussed (Nusbaum et al., 2004). These same women were also interested in scheduling a follow-up appointment specifically to address their sexual health concerns if their regular office visit did not allow time to fully discuss with their physician, although 84% reported that the routine office visit did allow enough time for these discussions to occur (Nusbaum et al., 2004).

In the large (n = 27,500) 29 country study of males and females 40 to 80 years of age regarding sexual health discussions with their general physicians within the past three years, 9% of all the males and 9.4% of all the females reported physician initiated discussions, and 42% of all males, 41.2% of all females, believe that the physician should routinely discuss sexual health during office visits (Moreira et al., 2005). In their study it was also reported that, for men and women, if the physician asked about their sexual activity and sexual health during routine visits they would be more likely to discuss their concerns and or problems, as well as seek medical treatment if needed (Moreira et al., 2005).

Older adults often cited embarrassment as a barrier to initiating sexual health discussions with their physicians, yet most reported they would welcome sexual activity

and sexual health discussions if their physician initiated the conversation (Camacho & Reyes-Ortiz, 2005; McAuliffe et al., 2007). This seems especially true for older women who are less likely than men to initiate discussions with their physicians or have their physician initiate conversations with them (Camacho & Reyes-Ortiz, 2005; Hillman, 2008). This embarrassment felt by the older adult may be compounded by the physicians' own discomfort in discussing sexual activity and sexual health with their older adult patients as patient barriers are influenced by the physician (McAuliffe et al., 2007).

Physician Characteristics and Sexual Health Discussions

Professionalism, being kind and understanding, appearing comfortable with the topic of older adult sexual health, and being empathetic has been reported by older women as physician characteristics that facilitate discussions (Nusbaum et al., 2004). Some women reported that having a female physician would make discussing their sexual activity and sexual health more comfortable, yet most women reported that gender of their physician did not deter their willingness to have such discussions (Nusbaum et al., 2004). Similarly, older women reported that the age of the physician, male or female, had no effects on their comfort in discussing their sexual activity or sexual health concerns, although a physician with a youthful appearance would deter them from initiating the discussion but they would have such discussions if the youthful appearing physician initiated the discussion (Nusbaum et al., 2004).

Discussing sexual health with older adults requires the same sensitivity and tact as with other age groups. It also requires the physicians' personal comfort with such discussions (Kennedy et al., 2010) and the ability of the physician to assist older adult

patients to feel comfortable with discussing their sexual activity and sexual health (Bancroft, 2007). Although no studies currently exist measuring physician personal comfort level in discussing sexual activity and sexual health with their older adult patients, lack of personal comfort is an often cited reason for not having these discussions with their older adult patients (Bauer, McAuliffe, & Nay, 2007; Benstrott & Margrett, 2011; Bouman et al, 2006; Gott et al., 2004; Hillman, 2011; McAuliffe et al., 2007). The distinction between professional discomfort, which can be attributed to education and training, and personal discomfort, which implies something embedded within the individual despite presence or absence of education and training, can be further explained by ageism and the stereotype embodiment theory.

To provide the best possible care to older adults, research indicated that the physician needs to let go of their incorrect ageist beliefs about older adult sexuality (Allen et al., 2009). Improvements to the educational requirements and the on-going training of physicians regarding the sexual activity and sexual health needs of older adults are influential in reducing ageism (Willet et al., 2007). Using a person-centered holistic approach when discussing sexual health with older adult patients has been beneficial in reducing ageist thoughts, beliefs and behaviors as the focus remains on the person, not the subconscious stereotyping of old age (McAuliffe et al., 2007).

Ageism

The term ageism was introduced in 1968 by Robert Butler to identify the collective stereotyping and discriminatory actions toward older adults based on chronological age (Butler, 1993; Phelan, 2008). The facets of ageism can be found within

myths and stereotypes of old age and aging, disdain and avoidance of older adults, discriminatory behaviors and practices in housing, employment opportunities and work place discrimination, and healthcare services (Butler, 1993). Ageism is also noted to be a socialization process in which the negative aspects of aging become accepted as societal norms that justify and reinforces the discriminatory behaviors toward older adults (Butler, 1993; Iverson, Larsen, & Solem, 2009; Phelan, 2008).

Research on ageism focuses on the causes, consequences, concepts, and ways to reduce negative attitudes toward aging (Iverson et al., 2009). The development of ageist thoughts, beliefs and behaviors are commonly agreed to be formed in early childhood experience and perceptions. One study, for example, reported that of the 60 cartoons reviewed 44 contained negative images of older adults, 6 were considered neutral in the representations of older adults, and 10 had positive representations of older adults (Mason et al., 2010).Watching how others, especially parents, react and behave toward older adults helps to form the internalized stereotype beliefs that guide future interactions, or lack thereof, with older adults (Levy, 2007; Moore, 2012).

Societal myths and negative stereotypes about older adults and the aging process have become accepted in the American culture (McGuire et al., 2008). Common beliefs of the older adult as being senile, dependent, burdensome, non-productive and diseased are titles that dominate the myths of aging (McGuire et al., 2008) and are generally accepted as societal norms (Magoteaux & Bonnivier, 2009). These myths contribute to societal stereotyping of older adults (Magoteaux & Bonnivier, 2009), as well as the development and reinforcement of ageist thoughts, beliefs and behaviors.

Ageism is consistently seen and accepted, yet often goes unnoticed as it can be very subtle in nature and display. In a study of 247 older adults aged 60 to 92 years, 84% reported being victim to at least one form of ageism and 71% reported being a victim of more than one form of ageism (McGuire et al., 2008). Within this study the number one form of ageism felt by the participants was being told a joke about older people, followed by receiving a birthday card that joked about older people or growing older, and the number three most commonly reported form of ageism was health concerns being assumed by the medical professional to be part of old age (McGuire et al., 2008).

Evidence has suggested that ageism can complicate the older adult's quality of life (North & Fiske, 2012). The myths and stereotypes associated with aging often influence the behaviors toward older adults. The belief that older adults are slow, lack in energy, and are feeble minded can lead to an over-helping behavior that does not allow for the older adult to maintain their independence creating a learned helplessness (Blakeborough, 2008). The assumption that older adults are hearing impaired or are declining in their cognitive and comprehensive abilities (Blakeborough, 2008; Langer, 2009) often leads to unnecessary loud talk or speech that mimics what one would use for a child (e.g., 'baby talk'). Other stereotypes that influence behaviors and attitudes toward older adults include the themes that older adults are not good drivers, they are inflexible and set in their ways, they are demanding, sick, diseased and healthcare seeking hypochondriacs (Blakeborough, 2008; Langer, 2009; Macik-Frey, 2013; Magoteaux & Bonnivier, 2009).

Chronological age, or the perception of being within an older age group, serves as a ranking system for societal and workplace productiveness whereas the young and those remaining to appear young, are essential members for survival, and those who are old or appear to be old are not essential for survival as they are viewed as weak and frail (Hagestadt & Uhlenberg, 2005). As with societal myths, the older worker, or older adult seeking employment, is stereotyped in much the same way. Older workers are considered slower and as having less stamina than their younger coworkers (Macik-Frey, 2013). For the older adult seeking employment, stereotypes and myths of older adults being less motivated to work, lacking in capacity and job performance capabilities, lack of commitment to employer due to being close to or at retirement age, and as being difficult to train may hinder their ability to become employed or remain employed (Macik-Frey, 2013).

Older adults do not meet the societal standards of youth and physical attractiveness (Bentrott & Margrett, 2011; Langer, 2009) and as such they are subjected to several stereotypes and myths regarding sexuality in old age. An older man is often noted to become distinguished looking as he grows older while an older woman has been noted to have lost her youthful beauty (Langer, 2009). With the lack of youthful vitality present, older adults are considered physically unattractive and undesirable (Langer, 2009). It is accepted that older adults have no sexual desires and any type of sexual activity can cause physical harm or even death in older age (Langer, 2009). For the older adults who remain sexually active, they are socially labeled as deviant, perverted, or

strange, as well as a person to be avoided due to their lack of moral societal standards (Langer, 2009).

Research Methodology

Based on the research questions and stereotype embodiment theory two researcher developed question and the SHCS-A standardized tool were used. Using stratified random sampling, Healthcare Data Solutions identified geriatricians and family practitioners within the United States. Stratified random sampling ensured that specific characteristics of the sample (e.g., males and females, geriatric physicians and general physicians) were represented in the sample and be reflective of the total population with these characteristics (Creswell, 2008). The two researcher developed questions contained closed questions with response options based on a 5-point Likert Scale. The SHCS-A contains closed questions with response options based on a 3-point Likert scale. Demographic information responses were categorical and were broken into categories based on a distribution analysis after data collection. The survey method was chosen because it would be very difficult and time consuming to observe physicians interact with their patients. Also, questionnaires allow for a broad range of participants, are easy for participants to do, and obtain data quickly (Myers & Hansen, 2002). This questionnaire only took physicians 5-10 minutes to complete thereby being less disruptive to their practice schedules.

The statistical program used was SPSS. The attitude constructs, independent to the focal construct (frequency of sexual health discussions) were related to the focal construct by the amount of influence they had on the responses (Teglasi, Nebbergall, &

Newman, 2012). The construct of personal factors were also influenced by the patient factor constructs and the focal construct, as well as an influence on the focal construct as it was assumed that those who frequently discuss sexual health with their older adult patients were more comfortable with such discussions despite the presence or absence of the patient factors. Statistical analysis of the questionnaire results used multiple regression to examine the distribution of frequencies for the two physician groups. Chapter 3 discusses methodology in further detail. A copy of the questionnaire can be found in Appendix A.

Summary

Probably the most important question to be studied is why healthcare providers are not asking older adults about their sexual health (Maes & Louis, 2003). This study used a non-experimental research survey to explore what predictive factors block or facilitate physician discussions of sexual health with their older adult patients. Previous studies in this area only used general physicians to gain knowledge of why these discussions did or did occur. This study used a comparative sample of geriatric physicians and general physicians. Stratified random sampling was used to identify eligible study participants within the United States. The physicians were e-mailed a link to the survey. The comparative results, of the geriatric physicians and the general physicians, were used to gain further insight and to identify the predictive factors that block or facilitate discussing sexual health with older adults. Chapter 3 discusses Methodology in further detail.

Chapter 3: Research Method

Introduction

This non-experimental quantitative study used two researcher-developed questions based on the literature review and the SHCS-A (Kim et al., 2011) to identify the factors that predict frequency of discussing sexual health with older adult patients using a comparative sample of geriatric physicians and general physicians. In this chapter, I discuss the research design and rationale, targeted survey participant eligibility, and sampling procedures. Issues pertaining to instrumentation, reliability, and validity are also discussed, as well as data analysis procedures and ethical considerations.

Research Design and Rationale

Research Question 1: Do geriatric physicians and general physicians equally discuss sexual health with their older adult patients?

Null Hypothesis 1: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's discussing sexual health with their older adult patients does not differ significantly from zero.

Alternative Hypothesis 1: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's discussing sexual health with their older adult patients does differ significantly from zero.

Research Question 2: Does age of the physicians predict the frequency of discussing sexual health with older adults?

Null Hypothesis 2: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's age does not differ significantly from zero.

Alternative Hypothesis 2: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's age does differ significantly from zero.

Research Question 3: Does gender of the physicians predict the frequency of discussing sexual health with older adults?

Null Hypothesis 3: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's gender does not differ significantly from zero.

Alternative Hypothesis 3: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's gender does differ significantly from zero.

Research Question 4: Do physicians report similar educational training that predicts the frequency of discussing sexual health with older adults?

Null Hypothesis 4: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's educational training does not differ significantly from zero.

Alternative Hypothesis 4: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's educational training does differ significantly from zero.

Research Question 5: Do physicians report personal factors that predict the frequency of discussing sexual health with their older adult?

Null Hypothesis 5: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting personal factors does not differ significantly from zero.

Alternative Hypothesis 5: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting personal factors does differ significantly from zero.

Research Question 6: Do physicians report patient factors that predict the frequency of discussing sexual health with older adults?

Null Hypothesis 6: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting patient factors does not differ significantly from zero.

Alternative Hypothesis 6: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting patient factors does differ significantly from zero.

Research Question 7: Do physicians report colleague factors that predict the frequency of discussing sexual health with older adults?

Null Hypothesis 7: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting colleague factors does not differ significantly from zero.

Alternative Hypothesis 7: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting colleague factors does differ significantly from zero.

Research Question 8: Do physicians report environmental factors that predict the frequency of discussing sexual health with older adults?

Null Hypothesis 8: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting environmental factors does not differ significantly from zero.

Alternative Hypothesis 8: After controlling for the other variables in the model, the standardized regression coefficient (β) for physician's reporting environmental factors does differ significantly from zero.

The use of an online questionnaire research design was chosen for this study. Using an online questionnaire allowed for a wider geographical range of participants and a more representative sample of the total population to be studied. The questionnaire took approximately 5 to 10 minutes for the physician to complete, thereby decreasing the amount of interference to his or her practice and patient time. This design choice was optimal to advance knowledge in discussing sexual activity and sexual health with older adult patients as it captured what factors needed to be present for these discussions to effectively occur.

The independent variable for this study was frequency of sexual health discussions with older adults. The predictor variables were type of physician, age of

physicians, gender of physicians, education of physicians, and the four subscale items: personal, patient, environmental, and colleague.

Participants

A link to the research survey and SHCS-A (Kim et al., 2011) was e-mailed to geriatric physicians and general physicians via Data Healthcare Solutions. This search consisted of all 50 states, allowing for geriatric physicians and general physicians from each state. Using a stratified random sampling, a geriatric physician and a general physician were selected for each state. If the physician, from either category, shared the same office as an already selected physician, he or she was considered ineligible for the survey and the next eligible physician was chosen. Based on a sample size calculation, I determined that a total of 108 participants, 54 for each group, would be needed (Gpower 3.1). This calculation was determined with a 5% error margin, a 95% confidence interval, and effect size of $F^2 = .15$. There are approximately 7,000 geriatric physicians (Peterson, Bazemore, Bragg, Xierali, & Warshaw, 2011) and about 100,000 general physicians (American Academy of Family Physicians, 2009) practicing in the United States. For balanced groups, the population was 14,000 to account for the considerably fewer number of geriatric physicians in comparison to general physicians.

Pilot Study

Pending IRB review and approval by the Walden Institutional Review Board (IRB), I conducted a pilot study to ascertain understanding of the survey and adequacy of the data analysis plan. The pilot study required six physicians, three geriatric physicians and three general physicians, to complete a hard-copy version of the survey: both the

researcher-developed questions and the SHCS-A (Kim et al., 2011) questions. Feedback from the pilot study survey and analysis concluded that no survey or methodology modifications were necessary.

Instrumentation and Measurement

This study employed a survey including two researcher-developed questions together with 17 questions from the SHCS-A (Kim et al., 2011). The following section describes the origin, development, and purpose of the researcher-developed questions. The section then describes the purpose, origins, sub-scales, validity and reliability, as well as the intended use of the SHCS-A (Kim et al., 2011). The first researcher-developed question was derived from past qualitative studies that reported that physicians rarely discussed sexual activity and sexual health with their older adult patients (Bilenchi et al., 2009; Bouman & Arcelus, 2001; Gott et al., 2004; Lindau et al., 2007; Smith et al., 2007) even though older adults have reported the routine office visits allows for enough time for discussions of sexual activity and sexual health to occur (Nusbaum et al., 2004). This was used to answer research question one and was used to identify the frequency in which geriatric physicians and general physicians discussed sexual health with their older adult patients during routine office visits. The second researcher-developed question was derived from past qualitative studies that reported that physicians are lacking in educational training and awareness in sexual activity and sexual health care needs of older adults (Bouman et al., 2006; Camacho & Reyes-Ortiz, 2005; Kennedy et al., 2010; Shippy & Karpiak, 2005). This was used to answer research question four by identifying

the influence of educational training on the frequency of discussing sexual health with older adult patients.

The SHCS-A is a 17 item, 4 factor, scale designed to evaluate attitude toward sexual health care among oncology nurses (Kim et al., 2011). The four factors, or subscales, are: 1. Discomfort in providing sexual health care, 2. Feeling uncertain of patient acceptance [of sexual health care], 3. Afraid of colleagues support, and 4. Lack of environmental support. Responses are based on a 3-point Likert scale with the choices being, “Agree”, “Uncertain” or “Disagree”. None of the four sub-scales of the SHCS-A (Kim et al., 2011) use the term *attitude* per se. However, the tool itself was constructed and intended to measure attitudes as reflected in its name. We believed and assumed each sub-scale contributes to overall attitude measurement.

The SHCS-A has demonstrated validity and reliability in evaluating attitude toward sexual health care in oncology nurses (Kim et al., 2011). The SHCS-A was originally 36 items however exploratory factor analysis showed that 70.49% of the variance in the responses related to attitude toward health care (within the 4 subscales). 19 items were deleted because they loaded at less than 0.40 or loaded on more than one factor (Kim et al., 2011). Cronbach alpha was used to evaluate reliability yielding a value of 0.92 with its coefficient for the four factors, or subscales, between 0.82 and 0.91. Concurrent validity, validated against the Sexual Attitudes and Beliefs Survey (Reynolds & Magnan, 2005), was established using the Pearson Correlation ($r= -0.57$, $p< 0.0001$).

The developers of this scale have noted that the SHCS-A can be used to measure the attitudinal barriers in oncology nurses as well as be used for the development and

testing of educational interventions for sexual health care improvement (Kim et al., 2011, p. 1529). Results of an extensive literature search showed no other studies using this scale other than the creators for their own study nor did it produce any existing scale for measuring physician attitude toward sexual health with older adult patients. The items on the SHCS-A (Kim et al., 2011) fit with the research questions and purpose of this paper. Items in subscale #1 reflect the personal factors of discomfort or embarrassment in discussing sexual health (RQ5). Subscale #2 deals with patient factors, such as acceptance of discussing sexual health (RQ6). Subscale #3, colleague factors, will serve as an indication as to what is considered common practice in discussing sexual health with older adults (RQ7). Subscale #4 deals with environmental factors which include time constraints and the routine office visit as being the appropriate place to discuss sexual health (RQ8). The assumption was that those who reported the least amount of the factors will have more discussions of sexual health with their older adult patients, as well as be more comfortable with such discussions.

SPSS was used to perform multiple regression analysis on the results for the two physician groups.

Operationalization of the Variables

Independent variables and predictor variables were based on the research questions.

Discussions of Sexual Health with Older Adult Patients

Discussions of sexual health with older adult patients was an ordinal scale measured by asking the geriatric physicians and general physicians to respond *never, rarely, sometimes, often* or *always* to the following question:

1. *"How often do you discuss sexual health with your older adult patients as part of their routine office visit?"*

Educational Training on Discussing Sexual Health with Older Adult Patients

Educational training on discussing sexual health with older adults was an interval scale measured by asking the geriatric physicians and general practitioners to respond *no training, poor training, minimal training, well trained* or *highly trained* to the following question:

3. *"How well do you feel you have been educationally trained to discuss sexual health with older adult patients?"*

SHCS-A Items

Patient subscale items that predict the frequency of discussing sexual health with older adults. Patient subscale items that predicted frequency of discussing sexual health with older adults was an interval scale measured by asking the geriatric physicians and general physicians to respond *agree, uncertain or disagree* to the following SHCS-A (Kim et al., 2011) items:

8. *"Patients would be uncomfortable if I broached sexual issues"*

9. *"I am afraid patients would feel their privacy was invaded if I asked specific questions about sex"*

10. *"I am afraid patients would be offended if I broached sexual issues"*

11. *"I am afraid conversation about sex with patients would bring a distance between me and them."*

Personal subscale items that predict the frequency of discussing sexual health with older adults. Personal subscale items that predicted frequency of discussing sexual health with older adult patients was an interval scale measured by asking the geriatric physicians and general physicians to respond *agree, uncertain or disagree* to the following items of the SHCS-A (Kim et al., 2011):

1. *"It is uncomfortable to discuss sexual issues with patients"*
2. *"I am reluctant to discuss sex with patients of the opposite sex"*
3. *"I feel uncomfortable discussing specific sexual activities with patients"*
4. *"I feel uncomfortable discussing sex with patients."*
5. *"I am not ready to discuss sex with patients"*
6. *"Discussing sex is a difficult thing to do"*
7. *"I may be embarrassed if patients broach sexual issues"*

Colleague subscale items that predict the frequency of sexual health discussions with older adults. Colleague subscale items that predicted discussing sexual health with older adult patients was an interval scale measured by asking the geriatric physicians and general physicians to respond *agree, uncertain or disagree* to the following items of the SHCS-A (Kim et al., 2011):

15. *"I am afraid my fellows would think it is unusual that I deal with patients' sexual issues"*

16. *"I am afraid my fellows would feel uncomfortable dealing with patients' sexual issues"*

17. *"My fellows also seem reluctant to talk about sex with older adults"*

Environmental subscale items that predict the frequency of discussing sexual health with older adults. Environmental subscale items that predicted frequency of discussing sexual health with older adults was an interval scale measured by asking the geriatric physicians and general physicians to respond *agree, uncertain* or *disagree* to the following items of the SHCS-A (Kim et al., 2011):

12. *"I am too busy to deal with sexual issues"*

13. *"It is hard to find a proper place where I can talk about sexual issues with patients"*

14. *"I do not have enough time to talk about sexual issues with patients"*

Data Analysis

To identify predictors of the frequency of physician-older adult patient sexual health discussions (RQ1) after controlling for demographic differences between physicians, a two-step hierarchical multiple regression analysis was employed. On the first step, the physician type [geriatric physician v general physician] (RQ1), age (RQ2), gender (RQ3), and educational training (RQ4) of the physicians was entered into the regression model. On the second step, the questionnaire subscales: personal subscale (RQ5), patient subscale (RQ6), colleague subscale (RQ7), and environmental subscale (RQ8) was entered into the model.

Threats to Validity

Internal threats to validity included the individual characteristic differences between study participants that may have had an effect on the results. These characteristic differences included years of practice, religious and cultural beliefs, gender bias, and the age discrepancy between younger physicians and older adults, especially among the patients with who are of opposite sex to the physician.

The external threats to validity included reactive bias and social desirability bias which affects the generalization to other physicians. With reactive bias, physicians may have assumed that the researcher can identify them and answer in a manner that they felt the researcher wanted them to and not how they truly behave or believe. In social desirability bias, physicians may have answered in a manner that they felt was more appropriate or correct and not indicative of how they really behave or believe. Physicians who decided to take the survey may be self-selected by the desire to contribute to science thus not reflective of other physicians.

Ethical Considerations

An informed consent form was e-mailed along with the survey questionnaire to all potential participants. The informed consent form discussed the risks and benefits of study participation, voluntary nature of study participation, confidentiality issues, procedures for participation, and a way to contact the researcher, her advisor and the appropriate Walden officials with individual questions regarding the study

All records in this study remain confidential and only the researcher has access to those records. Data files are encrypted and backed up by an external hard-drive which

remains in a locked box. The locked box also contains any paper files, hand written notes or data that could identify the participants (e.g., list of potential participants) in which only the researcher has possession and access to the key. This locked box is stored within the researchers' home in a location free from the elements or potential hazardous threats to safety. There were no physical risks or benefits to study participation. However, there was potential for emotional upset as participants were asked to reflect upon their own feelings and possible bias. Participants were made aware in the informed consent that they are not obligated to participate in this study or to answer any question in which they were uncomfortable answering.

Summary

This chapter included the methods used in this quantitative research survey study. Issues related to research design; participant selection, instrumentation validity and reliability, and data analysis were described. This study was designed to identify what factors block or facilitate discussing sexual health with older adult patients. Comparing the responses from the geriatric physicians and general physicians identified the influencing and deterring factors for such discussions to occur. Ethical considerations were discussed and the steps taken to protect the confidentiality of the study participants.

Chapter 4: Results

Introduction

The purpose of this current study was to quantitatively examine the predictors of physician-patient discussions of sexual health with older adults as part of the routine office visit. After gaining IRB approval (07-14-14-0273936), a total of eight hypotheses were tested using chi square analysis and linear regression. This chapter presents participant demographics, study results, and summary of the findings.

Pilot Study

Feedback from the pilot study participants, three geriatric physicians and three family practitioners, indicated understanding of the survey questions. The data analysis plan was found to be adequate; no modifications to the proposed methodology were needed.

Data Collection

Data were collected over a 60-day time period to reach the goal of a total of 108 participants. Participants were sent an e-mail invitation, containing the consent form and the survey link (surveymonkey.com), as well as given the opportunity to complete a hard-copy version of the survey.

Participant Demographics

Study participants included a total of 108 self-identified geriatric physicians (n = 55) and family practitioners (n = 53). Within each group, 62 were male (geriatric physicians = 34, family practitioners = 28) and 46 were female (geriatric physicians = 21, family practitioners = 25). Ages of the physicians ranged from 31 to 75 years (M = 50.2,

SD = 11.8). A large majority of the physicians reported their ethnicity as White (71.3%). Black/African American accounted for 7.4% of the participants, 1.9% were Hispanic or Latino, and 1.9% were Asian American. Only 5.6% of the participants indicated "Other or Mixed Race," and 12.0% indicated they preferred not to answer question regarding ethnicity.

Study Results

Research Question 1. Do geriatric physicians and general physicians equally discuss sexual health with their older adult patients?

Analysis of the physicians' responses was conducted to assess the frequency of sexual health discussions with older adults. Frequency of sexual health discussions (FSHD) with older adults was cross tabulated with physician type (geriatric physician and family practitioner) and analyzed using the chi-square test and SPSS software.

Results of the chi-square test indicated that a significant relationship existed between physician type and FSHD with older adults ($\chi^2(4) = 19.254$, $p < .001$), and the effect size, Cramer's V ($V = .422$), indicated a moderately strong relationship between FSHD with older adults and physician type.

As reported in Table 1, the geriatric physicians discussed sexual health with older adults significantly more frequently than did the family practitioners. Of the geriatric physicians, 38% reported they discussed sexual health with older adults as part of the routine office visit *often* or *always* as compared to 18.9% of the family practitioners. Slightly over half, 52.8%, of the family practitioners reported they discussed sexual

health with older adults as part of the routine office visit *rarely* or *never* as compared to 33.3% of the geriatric physicians.

Table 1

Cross Tabulation of Frequency of Sexual Health Discussions with Older Adults as Part of the Routine Office Visit by Physician Type

		Never	Rarely	Sometimes	Often	Always	Total
Family Practitioner	Count	4	24	15	10	0	53
	%within specialty	7.5%	45.3%	28.3%	18.9%	0.0%	
Geriatric Medicine	Count	0	8	26	20	1	55
	%within specialty	0.0%	14.5%	47.3%	36.4%	1.8%	
Total	Count	4	32	41	30	1	108
	%within specialty	3.7%	29.6%	38.0%	27.8%	0.9%	100%

Research Question 2. Does age of the physician predict the frequency of discussing sexual health with older adults?

Analysis of the physicians' responses was conducted to assess the relationship between physician age and FSHD with older adults as part of the routine office visit. Age

of the physicians (N = 108) ranged from 31 to 75 years (M = 50.2, SD = 11.8) and was analyzed using regression analysis and SPSS software.

As reported in Table 2, the results indicated that age of the physician was significantly and positively related to the FSHD with older adults as part of the routine office visit (r (107) =.597, r^2 = .357, p < .001), with a large effect size. The results also indicated that as the age of the physician increased the more frequently discussions of sexual health with older adults as part of the routine office visit would occur.

Table 2

Summary of Regression Analysis for the Variable Age Predicting Frequency of Sexual Health Discussions with Older Adults as Part of the Routine Office Visit

Measure	*B*	*SE B*	β	r^2	*t*	*p*
(constant)	.713	.297			2.404	.018
What is your age?	.044	.006	.597	.356	7.664	<.001

Research Question 3. Does gender of the physician predict the frequency of discussing sexual health with older adults?

Analysis was conducted to assess the relationship between physician gender and FSHD with older adults as part of the routine office visit. Of the total physicians (N =

108), 62 were male and 46 were female, and data were analyzed using the chi-square test and SPSS software.

Results of this analysis indicated that physician gender was related to FSHD with older adults as part of the routine office visit ($\chi^2(4) = 12.9$, $p < .001$), and the effect size, Cramer's V ($V = .347$), indicating a strong relationship between physician gender and FSHD as part of the routine office visit.

As reported in Table 3, male physicians had more frequent discussions of sexual health with older adult patients as part of the routine office visit as compared to female physicians. Of the male physicians, 69% indicated that they *sometimes*, *often*, or *always* discussed sexual health with older adults as part of the routine office visit, as compared to 63% of the female physicians. In contrast, 36% of the female physicians indicated they, *never* or *rarely* discussed sexual health with older adults as part of the routine office visit, as compared to 30% of the male physicians.

Table 3

Cross Tabulation of Frequency of Sexual Health Discussions with Older Adults as Part of the Routine Office Visit by Gender of Physician

Physician Gender	Never	Rarely	Sometimes	Often	Always
Male	2	17	18	25	0
Female	2	15	23	5	1

Research Question 4. Do physicians report similar educational training with regard to discussing sexual health?

Analysis of the physicians was conducted to assess the level of educational training. Level of educational training was cross tabulated with physician type (geriatric physician and family practitioner) and analyzed using the chi-square test and SPSS software.

Results of the chi-square test indicated level of educational training differed significantly among the physician type ($\chi^2(4) = 20.662$, $p < .001$), and the effect size, Cramer's V ($V = .437$), indicated a moderately strong relationship between level of education and physician type.

As reported in Table 4, 83% of the geriatric physicians, as compared to 45% of the family practitioners, indicated that they felt they had *minimally training*, *well trained* or *highly trained* in regard to discussing sexual health with older adults. Of the geriatric physicians, 16% indicated that they felt they had *poor training* or *no training* as compared to 54% of the family practitioners in regard to discussing sexual health with older adults.

Table 4

Cross Tabulation of Level of Education in Regard to Discussing Sexual Health with Older Adults by Physician Type

Physician Type	No Training	Poor Training	Minimal Training	Well Trained	Highly Trained
Family Practitioner	2	27	14	9	1
Geriatric Physician	3	6	28	17	1

Analysis of the Four Subscale Variables

Analyses were also conducted to assess the relationship between the personal subscale, patient subscale, environmental subscale, colleague subscale and FSHD with older adults as part of the routine office visit and was analyzed using multiple regression and SPSS software.

To examine the relationship between the subscale variables on FSHD with older adults as part of the routine office visit, a multiple regression analysis was conducted in which all four subscales were entered into the regression simultaneously. Table 5 displays the results of the analysis. The overall model was statistically significant and accounted for approximately 37% of the variability in the FSHD with older adults as part of the routine office visit, representing a large effect size (F (4,103) = 15.147, $p < .001$, $R^2 = .370$), adjusted $R^2 = .346$.

Table 5

Overall Model Summary for the Four Subscales: Personal, Patient, Environmental, and Colleague

	SS	*Df*	*MS*	*F*	*p*
Regression	30.150	4	7.538	15.147	*<.001*
Residual	51.257	103	.498		
Total	81.407	107			

An examination of the regression weights appear in Table 6 indicate that after controlling for the other predictors in the model, the personal subscale (RQ 5: Do physicians report personal factors that predict frequency of sexual health discussions with older adults as part of the routine office visit?) identifying how comfortable the physicians are with discussing sexual health with older adults, had a positive and significant relationship with FSHD with older adults as part of the routine office visit ($\beta = .387$, $p < .001$) and accounted for approximately 15% of the variability.

After controlling for the other predictors in the model, the patient subscale (RQ6: Do physicians report patient factors that predict the frequency of sexual health discussions with older adults as part of the routine office visit?) identifying how the physician perceives the older adult will feel discussing sexual health, also was positively related to FSHD with older adults as part of the routine office visit ($\beta = .329$, $p < .001$) and accounted for approximately 10% of the variability.

After controlling for the other predictors in the model, the environmental subscale (RQ7: Do physicians report environmental factors that predict frequency of sexual health

discussions with older adults as part of the routine office visit?) relating to time and place for discussing sexual health, was not a significant predictor of the FSHD with older adults as part of the routine office visit (p = .688).

After controlling for the other predictors in the model, the colleague subscale (RQ8: Do physicians report colleague factors that predict the frequency of sexual health discussions with older adults as part of the routine office visit?) relating to what the physician perceives as common practice among their peers, was also not a significant predictor of the FSHD with older adults as part of the routine office visit (p = .928).

Table 6

Summary of Regression Analysis for the Personal, Patient, Environmental, and Colleague Subscales Predicting the Frequency of Sexual Health Discussions with Older Adults as Part of the Routine Office Visit

	B	*SEB*	β	Sr^2	*t*	*p*
(constant)	-.515	4.88			-1.057	.293
Personal	.099	.023	.387	.153	4.328	<.001
Patient	.155	.043	.329	.109	3.558	.001
Environmental	.020	.049	.035	<.000	.403	.688
Colleague	.005	.059	.009	<.000	.091	.928

Summary

Based on the present findings, it appears that frequency of sexual health discussions with older adults as part of the routine office visit is significantly related to the physician type, age and gender, and how well the physician believes they have been

educationally trained to discuss sexual health with older adults. The frequency of sexual health discussions with older adults as part of the routine office visit was also found to be related to the four subscale variables (personal, patient, environmental, and colleague). Surprisingly, after controlling for other subscale variables, the environmental subscale and the colleague subscale was not a significant predictor of sexual health discussions with older adults as part of the routine office visit.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore whether geriatric physicians reported more frequent discussions of sexual health with older adults as part of the routine office visit than family practitioners did. The predictors that facilitated these discussions were quantitatively examined to identify the impact of physician age and gender, physician comfort level, ageist beliefs, environmental factors, colleague factors, and educational training on the frequency of sexual health discussions with older adults. This chapter presents the interpretation of the findings, limitations of the study, recommendations, implications, and conclusion.

Interpretation of the Findings

The findings of this study indicated that the geriatric physicians had more frequent discussions of sexual health with older adult patients than the family practitioners did. However, when examining the other predictors to discussing sexual health with older adults, the age of the physician was a strong predictor of the frequency of discussion. The older the physician, from both groups, the more frequently discussions of sexual health with older adults occurred. This result would need further study because at present it can only be assumed that the older age of the physician may indicate a more personal understanding of the sexual health needs of the older adult as the physician is entering or is in that age cohort.

Relationship to Previous Studies

Comparatively, the geriatric physicians had more frequent discussions of sexual health with older adults as part of the routine office visit than the family practitioners did. This result was not surprising as I had assumed that the geriatric physicians, based on specialty area, would have more sexual health discussions with older adults. This result confirmed previous studies, which suggested increased aging process knowledge, increased exposure, and increased familiarity with older adults can have an impact on reducing ageist beliefs and increasing frequency of sexual health discussions with older adults (Hagestad & Uhlenberg, 2005; Kane, 2008; Lindau et al., 2007; Pettigrew, 1998). Whereas, family practitioners are limited in their aging process knowledge, especially in the areas of sexual activity and sexual health needs (Comacho & Reyes-Ortiz, 2005).

The physician age and gender were found to be a positive predictor of frequency of sexual health discussions with older adults. It was found that the male physicians discussed sexual health more often than the female physicians and that as the physician age increased, the frequency of sexual health discussions with older adults increased. Previous studies of physicians did not report on this. However, it was reported in previous studies of older adults that age and gender of the physician did not have an impact on the older adults' comfort level with discussing sexual health as a part of the routine office visit (Nusbaum et al., 2004).

Authors of previous studies have reported that education, especially in regards to ageing process knowledge and older adult sexual activity, was a reducer of ageist beliefs, thoughts, and behaviors (subconscious and conscious) and was a positive indicator of

personal and professional comfort level with discussing sexual activity and sexual health with older adults (Cottle & Glover, 2007; Kane, 2008; Lindau et al., 2007). How well the physicians felt they were educated to discuss sexual health with older adults was a positive and significant predictor of the frequency of sexual health discussions with older adults as part of the routine office visit; the more educated the physician felt he or she was, the more frequently discussions occurred.

Despite physician comfort level being often cited as the reason for the lack of physician-older adult discussions of sexual health (Bauer et al., 2007; Benstrott & Margrett, 2011; Bouman et al., 2006; Gott et al., 2004; Hillman, 2011; McAuliffe et al., 2007), previous studies did not include this in their studies with physicians. Physician comfort level, as measured by the personal subscale, was found to be a significant and positive predictor of the frequency of sexual health discussions with older adults as part of the routine office visit. In a study of older adults, it was reported that the physician appearing comfortable discussing sexual health contributed positively to the older adult patients' comfort level with the discussion (Nusbaum et al., 2004).

Discussing sexual health with older adults requires the physician to have a personal and professional comfort with the discussion and the physicians' ability to assist the older adult patient to feel comfortable as well (Bancroft, 2007; Kennedy et al., 2010). How the physician perceived the patient acceptance of having discussions of sexual health, as measured by the patient subscale, impacted the frequency of sexual health discussions. Those physicians that perceived the older adults as accepting of the discussion had more frequent discussions of sexual health as part of the routine office

visit. Past studies have concluded that ageist beliefs of the older adults as not being sexual active, not having sexual health concerns, and as being unwilling to discuss sexual health can influence the physician to not discuss sexual issues with the older adult (Maes & Louis, 2003; Orel et al., 2005).

Authors of previous studies have reported that physicians believed the routine office visit was not the appropriate place or time to discuss sexual health with older adults as the presenting problem was of the main concern (Nusbaum & Hamilton, 2002; Pakpreo, 2005). However, as measured by the environmental subscale, time and place was not found to be a significant predictor of the frequency of sexual health discussions with older adults as part of the routine office visit.

How physicians perceived their colleagues' acceptance of them discussing sexual health with older adults, as measured by the colleague subscale, was also not a significant predictor of the frequency of sexual health discussions with older adults as part of the routine office visit. This was not included in previous studies, yet findings related to what is considered common practice norms among peers as noted on the SHCS-A (Kim et al., 2011).

Relationship to Stereotype Embodiment Theory

The theoretical framework for this study was rooted in stereotype embodiment theory (Levy, 2009), which states that ageist thoughts, beliefs, and behaviors are subconsciously acted upon as a result of lifetime exposure to ageist ideals. Past studies have reported ageist thoughts, beliefs, and behaviors in children as young as 4 years of age and have also noted the same ageist thoughts, beliefs, and behaviors among those

who work with older adults (Cottle & Glover, 2007). It is believed that the lifetime exposure to societal and cultural norms that negatively view or portray older adult sexuality and as a topic not to be discussed can influence the physician's willingness and ability to have sexual health discussions with his or her older adult patients (Allen et al., 2009; Brennan et al., 2011).

Increased aging process knowledge, as found within education, has been noted to be influential in decreasing ageist ideals and increasing sexual health discussions between physicians and older adult patients (McAuliffe et al., 2007). Whereas, limited or lack of educational learning reinforces ageist ideals (McAuliffe et al., 2007). This study has shown that geriatric physicians were discussing sexual health with their older adult patients as part of the routine office visit more frequently than the family practitioners were. This may be, in part, attributed to the lower levels of ageist beliefs due to increased specialty area knowledge held by the geriatric physicians.

This study also concluded that those physicians who were more comfortable and felt they were more educated in regard to discussing sexual health with older adults had more frequent discussions of sexual health as part of the routine office visit. It is speculated that there is a link between comfort level and educational training; however, that is beyond the scope of this current study and needs further investigation. What is known is that past research has concluded that familiarity and exposure to older adults, combined with educational knowledge of the aging process, can positively influence discussions of sexual health with older adults by reducing ageist ideals (Hagestad & Uhlenberg, 2005; Kane, 2008; Lindau et al., 2007; Pettigrew, 1998).

Limitations of the Study

It was assumed that both the geriatric physicians and the family practitioners had older adults in their practice. However it was not known how many, or how often, the family practitioners treat older adults. This may have limited their exposure and familiarity with older adults and their specific sexual health needs. It was also assumed that the geriatric physicians were more educationally trained to discuss sexual health with older adults, yet the specifics of this training are not known. It was also unknown what specific training the family practitioner had or has in regards to the aging process and older adult sexuality. Therefore the findings of this study are limited to geriatric physicians and family practitioners and should only be generalized to these practice areas.

Recommendations

Older adults have identified physicians as the appropriate source to discuss their sexual activity and sexual health needs (Gott et al., 2004). As such, older adults expect their physician to be knowledgeable about late-life sexual health needs and concerns (Kennedy et al., 2010). It would be recommended that physicians, both geriatric and family, increase their aging process knowledge, especially in regard to late-life sexual health needs and concerns.

Sexual activity and sexual health remains and important aspect of the older adult's overall well-being and a positive quality indicator of life-satisfaction (Benstrott & Margaret, 2011; Hillman, 2011; Kane, 2008; McAuliffe et al., 2007; Nusbaum et al., 2004; Thompson et al., 2011). It would be recommended that Health Psychologists

working with older adults also discuss sexual activity and sexual health needs. Health Psychologists can provide informative literature (i.e., Brochures and Pamphlets) to older adults, and physicians, specifically regarding sexual risks associated with aging and how both physician and older adult can effectively have these discussions.

The only direct comparison between the geriatric physicians and family practitioners was in the frequency of sexual health discussions. It would be recommended that future studies compare responses between groups for all survey response answers and subscales to gain further insight and understanding of the results. The participants of this study, although relatively equal in physician type and gender, were largely white. It would be recommended that future studies incorporate a greater ethnical mix in participants to explore the influence of ethnical and cultural norms toward discussing sexual health with older adults. The influence of colleague factors on frequency of sexual health discussions with older adults would also be recommended for future studies since it is unknown at this time what is considered common practice

Implications

The implications for social change from this research study was to raise awareness of the need for more specialized training in how to discuss sexual activity and sexual health with older adults to provide a true holistic approach to older adult health care. Awareness of, and discussions of, sexual health with older adults can improve the older adult's mental health well-being. Sexual problems in older age have been linked to medication non-compliance (Hillman, 2008; Lindau et al., 2007), depression and withdrawal, and as a consequence or warning sign of underlying medical conditions such

as diabetes, infection, urogenital tract conditions, and cancer (Bitzer at al., 2008; Lindau et al., 2007; Thompson et al., 2011).

Improvements to educational training, curriculum and on-going, in regard to older adult sexual health can be influential in providing not only the knowledge needed to effectively discuss sexual health with older adults, but also improve personal comfort with such discussions, as well as the ability to make older adults more comfortable with the discussion. Having effective discussions with older adults regarding sexual activity and sexual health can lead to improved medication compliance, improved overall mental health well-being, and reduction in the rising incidents of undiagnosed and misdiagnosed STIs and STDs among older adults.

Conclusion

Population estimates have reported that currently there are 40.3 million older adults age 65 and over in the United States (U.S. Census, 2011). By the year 2030 it has been estimated that one out of every eight American will be age 65 and over with those over 85 years being the fastest growing age group (Narang et al., 2010). Past studies have concluded that older adults continue to be sexually active throughout their life-span and were often misinformed or less knowledgeable regarding their sexual health risks. Not discussing sexual activity with older adults puts the older adult at an increased risk for infection (Williams & Donnelly, 2002) and leads to major public health implications (Bilenchi et al., 2009; Lindau et al., 2007; Lynch, 2012; Paul et al., 2007; Snyder & Zweig, 2010).

Geriatric physicians are discussing sexual health with older adults more frequently than the family practitioners. As gained by including geriatric physicians in the study, this result indicates that increased education regarding the aging process and late-life sexual health needs can positively predict the frequency of sexual health discussions with older adults. Thereby decreasing the negative effects of the stereotype embodiment theory and fostering a true holistic approach to older adult health care and healthy aging.

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Appendix A: Survey

Please check one response for the following question.

1. How often do you discuss sexual health with your older adult patients as part of their routine office visit?
   - ☐ Never
   - ☐ Rarely
   - € Sometimes
   - € Often
   - € Always

2. Please rate each of the following statements according to whether you agree, are uncertain, or disagree with the statement. Please circle one response for each statement.

	AGREE	UNCERTAIN	DISAGREE
It is uncomfortable to discuss sexual issues with patients	1	2	3
I am reluctant to discuss sex with patients of the opposite sex	1	2	3
I feel uncomfortable discussing specific sexual activities with patients	1	2	3
I feel uncomfortable discussing sex with patients	1	2	3
I am not ready to talk about sexual issues with patients	1	2	3
Discussing sex is a difficult thing to do	1	2	3
I may be embarrassed if patients broach sexual issues	1	2	3
Patients would be uncomfortable if I broached sexual issues	1	2	3
I am afraid patients would feel their privacy was invaded if I asked specific questions about sex	1	2	3
I am afraid patients would be offended if I broached sexual issues	1	2	3
I am afraid conversation about sex with patients would bring about a distance between me and them	1	2	3

I am too busy to deal with sexual issues 1 2 3

It is hard to find a proper place where I can talk about sexual issues with patients 1 2 3

I do not have enough time to talk about sexual issues with patients 1 2 3

I am afraid my fellows would think it is unusual that I deal with patients' sexual issues 1 2 3

I am afraid my fellows would feel uncomfortable dealing with patients' sexual issues 1 2 3

My fellows also seem to be reluctant to talk about sex with older adult patients 1 2 3

Please check one response to the following question:

3. How well do you feel you have been educationally trained to discuss sexual health with your older adult patients?

- € No training
- € Poor training
- € Minimal training
- € Well trained
- € Highly trained

4. General Demographics. Please check or answer the following:

What is your practice specialty: ☐ Geriatric Medicine ☐ Family Practitioner

What is your gender? ☐ Male ☐Female

What is your age? _____years

What is your race/ethnicity?

☐ White ☐ Black/African American ☐ Hispanic or Latino

☐ Asian American ☐ American Indian or Alaskan Native

☐ Native Hawaiian and other Pacific Islander

€ Other or Mixed Race

€ Prefer not to answer

Curriculum Vitae

Dana Marie Werner
267-615-3388
wernerbutterfly@gmail.com

Professional Profile

- 20+ years of experience working with older adults and their loved ones
- Knowledge and understanding of Federal and State Regulations regarding older adult care
- Experienced in group, individual and family therapy
- Dedicated to providing holistic care
- Strong sense of ethical integrity

Education

PhD Psychology, specialization in Health Psychology **February 2015**
Walden University, Minneapolis Minnesota

Master of Health Administration, specialization in Gerontology **2009**
University of Phoenix, Phoenix Arizona

Bachelor of Arts in Gerontology **2000**
Gwynedd-Mercy College, Gwynedd Valley, Pennsylvania

Associate of Applied Science in Human Services, specialization in Gerontology 1997

Montgomery County Community College, Blue Bell Pennsylvania

Employment/Professional Development

Brookside Nursing and Rehabilitation **2009-2010**
120 bed skilled long and short term care geriatric nursing and rehabilitation facility located in Roslyn Pennsylvania. Implemented policies and protocols for the Social Services Department. This included patient care planning, admission and discharge procedures, psychotropic drug monitoring, psycho-social assessments, family caregiving and staff/resident training on Resident Rights.

Dresher Hill Nursing and Rehabilitation 2008-2009
125 bed skilled long term and short term care nursing and rehabilitation facility located in Dresher Pennsylvania. Primarily worked with dual-diagnosed residents to find proper

and safe housing after discharge from facility. Decreased the homeless resident population from 80% to 10% to open up more beds for geriatric care.

Fox Sub-Acute 2008

140 bed skilled ventilator facility located in Warrington Pennsylvania. Provide one to one family support for end-of-life decisions.

Luther Woods Convalescent Center 2004-2008

120 bed skilled geriatric long and short term care rehabilitation facility located in Hatboro Pennsylvania. Implemented the psychotropic flow sheet and monitoring. Initiated the monthly family support group.

- **Sales and Counseling, Sunset Memorial Park,** 2003-2004
- **Center Director/Social Service Director, Beelong Adult Day Center,** 2002-2003
- **Director of Social Services, Senior Care of Willow Grove,** 2000-2002
- **Receptionist, Willow Lake Assisted Living,** 1997-2000
- **Personal Care Assistant, Willow Lake Assisted Living,** 1992-1997
- **Dietary Server, Spring House Estates,** 1984- 1989

Affiliations and Awards

- PSI CHI #1064876
- Past Commander of American Legion Liberty Post 308
- Past Junior Vice of American Legion Liberty Post 308
- Past Sargent at Arms American Legion Liberty Post 308
- Alpha Sigma Lambda Honor Society, Summa Cum Laude (BA)
- Consecutive Deans List (AAS)